

SF 71  
Revised 3/79  
OFFICE OF PERSONNEL MANAGEMENT  
FPM SUPPL. PPG-2, 6-7-P

## APPLICATION FOR LEAVE

71-112

INSTRUCTIONS: Please complete Items 1-8 after reading the Privacy Act Statement shown below.

1. Name (Print or type - Last, First, M.I.)  
**SEKIYA, L**

2. Employee ID. Number

3. Organizational Unit  
**DEMO-HI**

3. I hereby request (If more than one box is checked, explain in Item 6.)  
Remarks:

Annual Leave. (Annual leave requested may not exceed the amount available for use during the leave year.)

Sick Leave. (Complete reverse side of form.)

Leave Without Pay.

Compensatory Time.

Other. (Specify)

4-A	Month	Day	Hour	A.M.	4-C
FROM:	6	4	0730		Total Number of Hours
4-B	Month	Day	Hour	P.M.	2.15
TO:	6	4	0945	A.M.	P.M.

6. Remarks

**Dr. Appy**

7. Employee's Signature

**Sekiya**

8. Date  
**6-4-01**

Date  
**6-6-01**

## OFFICIAL ACTION ON APPLICATION

Approved     Disapproved (If disapproved, give reason. If annual leave, initiate action to reschedule.)

Signature (Annual leave approved may not exceed the amount available for use during the leave year.)

**Dodfrey**

**RAMAKRISHNA R. KOSURI, M.D.**  
PORTER ORTHOPEDIC REHABILITATION INCORPORATED  
615 PIKOI STREET, SUITE 1210  
HONOLULU, HAWAII 96814  
PHONE: (808) 596-7300

NAME **Sekiya, Linda**

ADDRESS \_\_\_\_\_

AGE \_\_\_\_\_

DATE **06-04-01**

**Rx** She is under my care for chronic RT foot pain due to plantar fasciitis. She is making progress, she needs to continue some more physical therapy sessions using night splint/heel cup.

LABEL \_\_\_\_\_  
REFILL \_\_\_\_\_ TIMES

**Rama Kosuri**  
DEA NO. BK 4607477 M.D.

**EXHIBIT HH**